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# ASSESSMENT OF HIV TESTING POLICY AND PRACTICES IN BENIN

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The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.



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## ABBREVIATIONS AND ACRONYMS

<b>AIDS</b>	acquired immunodeficiency syndrome
<b>AMCES</b>	<i>Association des Oeuvres Médicales Privées Confessionnelles et Sociales</i> (Association of Private, Mission and Social Health Institutions)
<b>APH</b>	<i>Aktion Pro Humanität</i> (Action for Humanity)
<b>ART</b>	antiretroviral therapy
<b>ARV</b>	antiretroviral (drugs, treatment, services)
<b>BHAPP</b>	Benin HIV/AIDS Prevention Program
<b>CCS</b>	<i>Centre Communal de Santé</i> (Parish Health Center)
<b>CERID</b>	<i>Centre de Recherche et d'Intervention pour le Développement</i>
<b>CFA</b>	<i>Communauté Financière Africaine franc</i> (currency)
<b>CHD</b>	<i>Centre Hospitalier Départemental</i> (District Hospital)
<b>CSA</b>	<i>Centre de Santé d'Arrondissement</i> (Parish Health Center)
<b>CSC</b>	<i>Centres de Santé [Urbains et] Communaux</i> (Communal Health Centers)
<b>CIPEC</b>	<i>Centre d'Informations, de Prospectives et de Conseils</i> (Information and Counseling Centers)
<b>CRS</b>	Catholic Relief Services
<b>CSCU</b>	<i>Centre de Santé de Circonscription Urbaine</i> (Urban Sub-District Health Center)
<b>CSSP</b>	<i>Centres de Santé de Sous-Prefecture</i> (Sub-District Health Center)
<b>DIST</b>	<i>Dispensaire des Infections Sexuellement Transmissibles</i> (Dispensary for STI)
<b>HIV</b>	human immunodeficiency virus
<b>HZ</b>	Health Zone
<b>MOH</b>	Ministry of Public Health ( <i>Ministère de la Santé Publique</i> )
<b>MSF</b>	<i>Médecins Sans Frontières</i> (Doctors Without Borders)
<b>NGO</b>	nongovernmental organization
<b>OSV</b>	<i>Organisation pour le Service et la Vie</i> (Organization for Service and Life)
<b>PLWHA</b>	people living with HIV/AIDS
<b>PMTCT</b>	prevention of mother-to-child transmission
<b>PNLS</b>	<i>Programme National de Lutte contre le SIDA</i> (National HIV/AIDS Control Program)
<b>PPLS</b>	<i>Projet Pluri-sectoriel de Lutte contre le VIH/SIDA</i> (Multisectoral Project for the Fight against HIV/AIDS)

<b>PROSAF</b>	<i>Promotion Intégrée de Santé Familiale</i> (Benin Integrated Family Health Program)
<b>PSI</b>	Population Services International
<b>STI</b>	sexually transmitted infection
<b>TB</b>	tuberculosis
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>VCT</b>	voluntary counseling and testing
<b>WHO</b>	World Health Organization

## EXECUTIVE SUMMARY

The concept of client-driven voluntary counseling and testing (VCT) and related policy guidelines promulgated by the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) remain in place today and continue to direct national responses in the fight against HIV/AIDS. Twenty years after the emergence of HIV/AIDS in Africa, the limitations of this policy and related program approaches to HIV counseling and testing are quite obvious. HIV counseling and testing interventions have demonstrated disappointing results in terms of the proportion of people tested and the disclosure of test results for prevention measures and protection of sexual partners.

Uganda is the African country that has achieved the most success in the fight against HIV/AIDS and has shown the greatest commitment to promoting HIV counseling and testing. Despite the great commitment of its leaders and heroic work performed by people living with HIV/AIDS, as of 2004, no more than 10% of Uganda's adult population had ever been tested; the disclosure level of test results among those who are HIV-positive to partners remains very low. Findings from the most successful and groundbreaking prevention of mother-to-child transmission (PMTCT) partnership research by Makerere University and Johns Hopkins University in Uganda show that no more than 15% of HIV-positive women have ever disclosed their HIV test results to their partners despite first-class, multifaceted, and sustained PMTCT plus interventions.

Today there is growing support for introducing complementary testing approaches to the current testing paradigm of client-initiated VCT services in order to scale up HIV testing interventions, to reduce both stigma and discrimination, and to achieve the key public health imperatives of testing and counseling. Such complementary approaches should 1) foster behavior change to help prevent further infections, and 2) increase access to care, treatment, and support for those infected.

Benin currently has the most experience with PMTCT and VCT interventions of all the countries in West Africa and has achieved important results in increasing availability, accessibility, and the use of PMTCT and VCT services, thanks to the leadership demonstrated by the Ministry of Health (MOH)/PMTCT program, the World Bank-supported Multisectoral Project for the Fight against HIV/AIDS (*Projet Pluri-sectoriel de Lutte contre le VIH/SIDA* (PPLS)), and financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Key norms and standards documents related to HIV/AIDS counseling and testing are currently in place, thanks to the support provided by the USAID-funded Benin HIV/AIDS Prevention Program (BHAPP). There is also a growing openness to HIV counseling and testing. Acceptance of HIV testing under the PMTCT program is nearly universal. Thanks to the World Bank project, about 2,512 villages (68% of all villages in Benin) have received multifaceted support for HIV/AIDS prevention. Through this support, no fewer than 82,602 people have been tested over a two-year period—June 2003–June 2005—of which 1,272 (1.53%) were found to be HIV-positive.

The HIV/AIDS program could also take advantage of two important existing laws relevant to HIV/AIDS prevention and care, namely Law 2003–04, passed in March 2003, and Law 2000, passed in August 2004, relating to the Sexual and Reproductive Health

and the Family Code, respectively. Key stakeholders are currently reviewing a specific draft law for fighting HIV/AIDS that will empower relevant authorities and players to further protect people living with HIV/AIDS, as well as the seronegative population.

USAID/Benin and implementing partners BHAPP and Population Services International have played a significant role in the current momentum achieved by Benin in the fight against HIV/AIDS generally and in HIV counseling and testing specifically. The experience of the Benin Integrated Family Health Program [*Promotion Intégrée de Santé Familiale* (PROSAF)] in fostering the integration of health services provides invaluable lessons for scaling up PMTCT and possibly introducing innovative, routine HIV testing services into the health delivery system.

This assessment of HIV testing policies and practices identifies three critical implementation gaps that need urgent attention in order to reconcile public health imperatives with the human rights protection of people living with HIV/AIDS. These assessment gaps include: 1) addressing the stigma and lack of disclosure of test results; 2) monitoring compliance against norms and standards; and 3) building a decentralized and supportive infrastructure for HIV/AIDS prevention, care, and support.

Recommendations resulting from this assessment are as follows:

1. USAID/Benin should build on the current momentum achieved in HIV testing and counseling and contribute to scaling up PMTCT, VCT, and antiretroviral (ARV) services by developing a collaboration with key HIV/AIDS stakeholders and making that collaboration the centerpiece of its program assistance strategy.
2. USAID/Benin should lead the realignment of testing and counseling interventions with the core public health imperatives of contributing to attitude and behavior change. Performance of implementing partners should not only be measured by the number of people tested, but also with the following illustrative performance indicators:
  - the proportion of people who received their test results
  - the proportion of people tested who shared their results with their partners
  - the proportion of people living with HIV/AIDS who experienced discrimination and accessed support services (including legal services)
3. USAID should first and foremost dedicate its resources to monitoring, documenting, and establishing a rapid feedback system that can: assess and address the implementation gaps affecting compliance with existing norms, standards, and protocols; and determine the achievement of public health objectives, as well as refine and disseminate lessons already learned and current effective interventions.
4. As the need and demand increase for stronger quality assurance systems for HIV testing and counseling services and all their underpinnings, it is important to put in place effective quality-assurance mechanisms for these services. Such mechanisms are presently only in an embryonic stage.

5. With the increased availability of rapid HIV tests, Benin should consider testing the best practice of same-day-testing/same-day-result and providing HIV testing in clinical settings for TB patients. Adopting this best practice would significantly increase the number of post-test counseling. Further, with other development partners, USAID/Benin should introduce routine HIV testing for TB patients in health centers.
6. An urgent need has arisen to support targeted prevention activities among clients who have tested positive or negative and among discordant partners. The focus of these prevention activities would be to support them to disclose their results to their partners. An important tool for positive clients to use to address discrimination will be laws related to HIV prevention and the fight against HIV/AIDS. However, it will be essential to disseminate such information and expand support mechanisms to facilitate access to legal services by PLWHA associations and other vulnerable populations. A vigorous, culturally sensitive support strategy for reducing social stigma and discrimination should accompany such prevention interventions among all tested clients.



## **BACKGROUND**

USAID/Benin is about to launch its new development assistance program in 2005-2006. Following the development of its HIV/AIDS strategy in 2004, the Mission's Family Health Team considers it important to conduct an assessment of HIV testing policies and practices in Benin to guide further assistance in this critical area of growing programmatic importance.

The specific objectives of this activity are to:

- Determine the existence of and assess the state of a policy of HIV testing of pregnant women and the general public, as well as the applicability of the policy
- Identify the appropriate mechanism for providing testing and counseling services to both pregnant women and the general public
- Describe community openness to voluntary counseling and testing (VCT) and prevention of mother-to-child transmission (PMTCT), including the willingness of pregnant women (or women of reproductive age) to use PMTCT services, and of the general public to use VCT services
- Assess the availability of various components of PMTCT [VCT; and antiretroviral (ARV) treatment, facilities, trained personnel, etc.] in Borgou/Alibori and Zou/Collines
- Determine the extent to which nongovernmental organization (NGO)/private sector VCT sites are available in Borgou/Alibori and Zou/Collines
- Determine other donors and MOH resources for PMTCT and NGO/private sector VCT sites in the Borgou/Alibori and Zou/Collines
- Provide recommendations for USAID Mission interventions in HIV/AIDS testing policy and guidelines

## **HIV/AIDS SITUATION**

The 2002 HIV validated sentinel survey suggests that overall HIV prevalence is about 1.9–2.1% in the general population. Recent data from voluntary testing and counseling activities confirm this relative HIV seroprevalence. Between June 2003 and June 2005, 82,602 people of reproductive age from 68% of all villages in Benin were tested and 1,272 (1.53%) were HIV-positive.<sup>1</sup>

HIV prevalence is higher among vulnerable populations that engage in high-risk behaviors, e.g., commercial sex workers. A survey of sexually transmitted infections (STIs) and HIV conducted by the Canada Cooperation-funded SIDA project in 2002 found the following infection rates in the interventions sites for the project's four focused districts:

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<sup>1</sup> Personal Communication from Dr. Olivier Capo-Chichi, National Coordinator, World Bank-funded Multisectoral Project for the Fight against HIV/AIDS

Table 1: Infection rates at SIDA project intervention sites in four focused districts in 2002						
Districts	HIV		<i>Neisseria gonorrhoeae</i>		<i>Chlamydia trachomatis</i>	
	N	% positive	N	% positive	N	% positive
Cotonou	192	38.5%	186	14.0%	186	4.8%
Porto-Novo	44	61.4%	45	35.6%	45	6.7%
Parakou	44	51.9%	44	27.3%	44	6.8%
Abomey	24	54.2%	24	29.2%	24	12.5%
<b>Total</b>	<b>304</b>	<b>46.1%</b>	<b>299</b>	<b>20.45</b>	<b>299</b>	<b>6.0%</b>

In 2004, the project offered voluntary testing services to 374 sex workers at six intervention sites.

Table 2: Results of voluntary testing services at six SIDA project intervention sites			
Sites	Number of people served	Number of people HIV-positive	
Dispensary for STI (DIST)	196	51	26.02%
Porto-Novo	3	0	0.0%
Bohicon	18	7	38.89%
Parakou	105	13	12.38%
Malanville	43	15	34.88%
CERID	9	2	22.22%
<b>Total</b>	<b>374</b>	<b>88</b>	<b>23.53%</b>

Based on this recent HIV data, the National AIDS Control Program [*Programme National de Lutte contre le SIDA* (PNLS)] estimates that about 70,000 people live with HIV/AIDS, including 15,000 (about 20–25%) who may be eligible for ARV treatment.<sup>2</sup> The rule of thumb is to estimate that 20–25% of people living with HIV/AIDS are eligible for antiretroviral therapy (ART).

<sup>2</sup> The basic eligibility requirement is to have the CD4 count less than 200. Other clinical factors may be also taken into consideration in relation to the CD4 count.

## HIV/AIDS TESTING IN THE WEST AFRICA SUB-REGION

The experience of West Africa in HIV/AIDS testing and the reach of HIV testing services still remain extremely limited. Indeed, Benin is one of the few West African countries with much experience, thanks to its bold and extensive pilot PMTCT program that utilizes 33 health centers. A review of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) proposals indicated that by 2002, West African countries had a lower HIV seroprevalence, compared with East and Southern Africa, and that West African countries were operating between one and five pilot, stand-alone VCT centers, with the exception of Mali. In Mali, 15 stand-alone VCT facilities were operational by 2002. Senegal had the most limited experience in VCT, with only one operating stand-alone site.

VCT testing in clinical settings was also provided at no more than six pilot PMTCT initiative sites. By 2002, there were only four PMTCT sites in Côte d'Ivoire and Ghana, five PMTCT sites in Mali and Togo, and six PMTCT sites in Nigeria. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), the number of people who avail themselves of VCT and PMTCT services still remains quite low. In Mali, which seems to have the most experience in promotion of VCT, only 4% and 9% of adult women and men, respectively, had been tested for HIV. Stigma and discrimination continue to be the main barriers to the demand and use of HIV testing services, once services are available. In addition, West African countries are struggling to meet the standards and principles set by UNAIDS for HIV testing of individuals. According to UNAIDS, testing of individuals must be "confidential; accompanied by counseling; and only conducted with informed consent," meaning that testing is both informed and voluntary.

A major lesson learned over the past 20 years is that there is a need to introduce complementary testing approaches to client-initiated VCT services in order to scale up interventions and reduce stigma and discrimination. **Provider-initiated** approaches in clinical and non-clinical settings are increasingly being promoted. The debate on the need for new principles and standards for HIV testing is progressing, albeit too slowly in some parts of Africa, especially when one considers the devastating short-term and long-term impact of the epidemic, the burden still placed on women to disclose their positive results to their male partners, and the increasing availability of care, treatment, and support services.

Uganda is the African country that has achieved the most success in the fight against HIV/AIDS and has shown the greatest commitment to promoting HIV counseling and testing. Despite the great commitment of its leaders and heroic work performed by the people living with HIV/AIDS, as of 2004, no more than 10% of its adult population had ever been tested, and disclosure level of test results by those who are HIV-positive to partners remains very low. Recent findings from the successful and groundbreaking PMTCT partnership research by Makerere University and Johns Hopkins University in Uganda show that no more than 15% of HIV-positive women have ever disclosed their HIV test results to their partners despite first-class, multifaceted, and sustained PMTCT *plus* interventions. The obvious recurrent reasons for this situation are related to stigma, the status of women, and, most importantly, the ineffectiveness of current proposed solutions. The same situation is observed in Benin, as discussed below.

## **METHODOLOGY**

A crucial aspect of this assessment was to understand the key challenges and constraints pertaining to HIV/AIDS testing and counseling, with attention directed toward the current level of stigma and discrimination. To collect pertinent information, we interviewed relevant representatives of all key players and stakeholders and reviewed available background documentation and reports. We also conducted selected site visits in the Atlantique, Mono, Zou, and Borgou/Albori districts. This assessment also built on the previous assessment in 2004 of the HIV/AIDS responses in Benin for USAID/Benin's HIV/AIDS strategy development.

The most critical public health reasons for promoting more HIV testing and counseling are threefold: 1) to contribute to behavior change among both seronegative and seropositive individuals and couples; 2) to encourage and direct people living with HIV/AIDS (PLWHA) to seek care and support; and 3) to encourage and direct eligible PLWHA to seek ART.

The most important interrelated contributions of HIV testing and counseling toward attitude and behavior change will be to:

- Provide critical information on HIV/AIDS during counseling sessions, as appropriate
- Motivate individuals and couples to know their serostatus for appropriate action
- Encourage partner involvement and notification
- Motivate clients to develop positive attitudes in addressing HIV/AIDS and adopt HIV-preventive measures, including safe sexual behaviors
- Motivate all clients to seek care, support, and treatment

This contribution cascade provides the basic framework for this assessment. Accordingly, the focus of this assessment is to: evaluate how and to what extent the various stakeholders engaged in promoting HIV testing and counseling are achieving the aforementioned objectives; identify any implementation gaps; and make recommendations to improve current performance with respect to the terms of reference of this assessment.

## **KEY FINDINGS**

### **DEVELOPMENT OF POLICIES, NORMS, STANDARDS, AND PROTOCOLS**

With the support of development and implementing partners, the MOH/PNLS, including the USAID-funded BHAPP, has achieved commendable success in developing the key norms and standards documents related to HIV/AIDS counseling and testing. These documents include the following:

- National norms and guidance for HIV/AIDS testing and laboratory support for people living with HIV/AIDS
- Norms and procedures for prevention of mother-to-child transmission
- Policy, norms, and procedures for STI management in Benin

- National strategies, norms, and procedures for behavior change communication
- Policy, norms, and procedures for caring and supporting those people living with HIV/AIDS

These documents are sound, comprehensive, and consistent with the June 2004 UNAIDS/World Health Organization (WHO) policy statement on HIV/AIDS testing. The documents provide a framework and empower service providers for delivery of HIV counseling and testing services, taking into account Benin's current experience in addressing HIV/AIDS. The document, titled "National Norms and Guidance for HIV/AIDS testing" also addresses specific situations and target groups. Some of these examples include HIV counseling and testing before and within marriage, for discordant couples, and for children and adolescents; and HIV counseling and testing and mandatory widow inheritance.

The client-driven voluntary model for delivery of HIV counseling and testing in Benin is the only model approved by the national authorities. New approaches are being tested in East and Southern Africa (in Uganda in particular), to increase access to care, including service-provider-driven, routine testing in clinical settings and home-based HIV counseling and testing. These new approaches, however, are not included in any of the aforementioned documents.

In Benin, certification of personnel who are qualified to provide counseling services is not just limited to qualified health and social workers. People living with HIV/AIDS are encouraged to apply for HIV counselor positions to provide complementary support to health service providers and to facilitate communication and linkage with the targeted communities.

However, within the laboratory infrastructure, only laboratory technicians from accredited laboratories are authorized to perform HIV testing. And trained nurses and midwives are authorized to perform rapid tests for VCT and PMTCT.

The national policy and norms document for HIV/AIDS testing highlights the importance of quality control of test results, specifying the role of the national reference and lower-level laboratories and defining specific procedures for quality assurance. The PMTCT program, for example, requires that every tenth sample be sent to an accredited laboratory for quality control. To date, blood transfusion centers at the district hospital have been performing this control task.

### **AVAILABILITY OF PMTCT, VCT, AND ARV SERVICES**

Availability of PMTCT, VCT, and ARV services, although relatively limited, is increasing rapidly as a result of the leadership demonstrated by the MOH/PMTCT program; and increased financial resources from the \$16 million Global Fund project and the three-year, \$25 million World Bank-funded Multisectoral Project for the Fight against HIV/AIDS (*Projet Pluri-sectoriel de Lutte contre le VIH/SIDA (PPLS)*) (2003–2006). The experiences of these two projects are discussed in more detail below.

It is noteworthy that the MOH has financed the construction of five district-based Information and Counseling Centers [*Centre d'Informations, de Prospectives Et de Conseils (CIPEC)*] designed to support the decentralization of the fight against HIV/AIDS

and to provide reference laboratory services for VCT, PMTCT, and ARV treatment. These CIPECs are staffed by contractual personnel and are equipped using Global Fund monies. Technical staff include two medical officers in charge of PMTCT and care and support, respectively, and a laboratory technician.

The Global Fund supports HIV/AIDS interventions developed by the PNLS in collaboration with all districts. As far as HIV testing is concerned, the PPLS and Global Fund are the main donors of test kits and supplies, ARV drugs, and other needed material. They also provide funding and technical support for training, supervision, and VCT outreach.

Currently 45 out of the preliminary list of 480 health centers (<10%) selected for PMTCT services provide these services. The MOH is mobilizing additional resources for expanding the reach of PMTCT services. See below discussion. Of the centers, 33 and 22 offer VCT and ARV services, respectively. As of December 2004, 841 service providers had received training in counseling. When compared to the number of health service providers operating at the district and sub-district level (as of 2003, 1,175 medical officers and 3,607 nurses/midwives), the proportion of service providers trained in counseling stands at 16%.

**PMTCT Services.** Benin's experience in HIV testing for HIV prevention focused on groups with high-risk behavior (e.g., sex workers, truckers, and STI clients) until the introduction of PMTCT interventions in June 2000. Multifaceted interventions among populations with high-risk behaviors have proven quite effective. These achievements were possible based on the collaborative and sustained interventions of a range of leading development and implementing partners, including USAID, Canada, German cooperation through *Kammerschaft für Wiederaufbau* (German Development Bank), the SIDA project, Population Services International (PSI), and BHAPP, MOH/PNLS, and local NGOs such as OSV Jordan.

Between June 2000 and August 2002, the MOH/PNLS used some remaining funding from the French Cooperation to introduce PMTCT interventions in 33 maternity health centers located in five Health Zones of the two health departments (districts) of Littoral and Atlantique. With the exception of the standardized PMTCT protocol, these interventions were implemented without any systematic approach or standardized tools. Nevertheless, this pilot phase was quite successful and prominently stood out when compared to similar experiences across Africa.

Table 3 lists the results of these successful interventions.

Table 3: PMTCT Interventions		
Indicators	Targets	Results
No. of health centers	36	33
No. of pregnant women tested	12,500	18,072
No. of pregnant women testing HIV-positive	500	773
Percent positive		4.3%
No. of HIV-positive women and babies who benefited from follow-up activities after delivery	250	285

Following an evaluation of the pilot phase, the MOH/PNLS, under the outstanding leadership of Dr. Adeyanju Isidore, completed a range of standardized tools, including PMTCT norms, standards, and procedures; a training curriculum; and a supervision framework.

The evaluation further recommended paying particular attention to the following critical issues for the expansion of the pilot initiative:

- male involvement
- societal support and mobilization
- regular and ongoing supply of test kits and consumables
- decentralized laboratory support

The PMTCT results of the extension phase, as of December 2004, are provided below.

Table 4: PMTCT Result, December 2004	
Indicators	Results
No. of health centers	45
No. of pregnant women tested	29,497
No. of pregnant women testing HIV-positive	1,154
Percent positive	3.9%
No. of HIV-positive women who benefited from follow-up activities after delivery	666
No. of HIV-positive babies who benefited from follow-up activities after delivery	670

MOH is currently working at mobilizing the necessary resources for the implementation of the PMTCT extension plan provided in Annex A. The PMTCT extension plan is presented according to pledges made by the specified partners. The MOH/PMTCT service has been working to secure these commitments and mobilize additional resources for further expansion.

**VCT Services.** The World Bank/PPLS project is the main player that is focusing substantial resources on encouraging people to seek testing and counseling. Its results are unique as far as the number tested for HIV is concerned. About 2,512 villages (68% of all villages in Benin) have received multifaceted support for HIV/AIDS prevention, care, and support through a small-grants program, not exceeding 1.5 million CFA (\$3,000) per village. The PPLS also designed and implemented a public-private partnership program engaging local NGOs and public and private health centers to provide support and comprehensive HIV services to these villages. It should be noted that PPLS has paid particular attention to the network of faith-based health delivery system. Through the implementation of this model, 82,602 people were tested over a two-year period—June 2003–June 2005—and 1,272 (1.53%) were found to be HIV-positive. Compared to the five-year PMTCT interventions that provided counseling and testing to about 30,000 mainly urban-based women to date, the two-year, World Bank-supported, grassroots counseling and testing initiative has taken these interventions to a new height.

Additional outstanding results from the PPLS include the following: More than 700 people living with HIV/AIDS have been enrolled in care and support activities, and have been provided with resources to build associations for income-generating activities. The total disbursement rate of 64.28% at 15 months before the end of the project is high. Additionally, 85% of the total project funding has been committed.

The response of the collaborating health centers to the growing demand for HIV testing and care has been inadequate. The World Bank PPLS project has been testing several approaches to increase accessibility and availability of HIV testing services. As indicated above, PPLS's core approach has placed an emphasis on the empowerment of villages/communities and their partnership with NGO and public health facilities. The emerging effective approach is to build a performance-based, contractual relationship between villages and health centers and have the villages pay private and public health centers according to the number of clients they serve.

**VCT and SIDA Project.** For about 12 years, the Canada-funded SIDA project has been strengthening STI case management and supporting STI/HIV/AIDS interventions for sex workers and their clients, including free HIV testing. Preliminary results of a recent mapping exercise of the prostitution network in Benin indicate that about 10,000 sex workers operate actively there. In 2004, the project offered testing services to 274 sex workers at six intervention sites [*Dispensaire des Infections Sexuellement Transmissibles* (DIST)], in Porto-Novo, Bohicon, Parakou, Malanville, and CERID).

**VCT, PSI, and the Military.** The military sector has made significant strides through the U.S. Department of Defense-funded PSI project that works collaboratively with the Government of Benin and the military leadership. There is an established mandatory HIV testing policy for new military recruits. Currently, all new military recruits are systematically counseled and tested for HIV as are any personnel traveling to peacekeeping operations.

About 700 military recruits and 600 peacekeeping military personnel are tested every year. A voluntary testing center, open to both the military and the civilian population, has been established at the Guezo military hospital to encourage the military to test for HIV.

***Tuberculosis (TB) and HIV/AIDS.*** Routine HIV testing of TB clients is not conducted. Tuberculosis, which once was in regression, is once again proving a major health problem in Benin. According to the annual report by the National Program against Tuberculosis, from 1990 to 2000, the number of detected cases increased by 62%. In 2000, there were 2,277 cases of positive pulmonary tuberculosis (smear positive). The frequency of the disease is 40 cases per 100,000 inhabitants, but in the large conurbations, it can reach 73 cases per 100,000 inhabitants (Cotonou). The HIV seroprevalence among TB patients increased from 2% in 1990 to 16% in 2000. The MOH has also expanded the TB program with support from the Global Fund.

***Antiretroviral Services.*** As of May 2005, 2,767 patients (18.44% of eligible clients) were enrolled in 22 ART centers, and 250 accredited medical officers had been trained in prescribing ARVs. When compared to the number of medical officers operating at district and sub-district levels (as of 2003, 1,175 medical officers), the proportion of medical officers trained in prescribing for ARV counseling stands at 21.27%. Private initiatives such as the Sedekon project supported by Catholic Relief Services (CRS) and Action for Humanity [*Aktion Pro Humanität* (APH)] have significantly contributed to these results, despite their limited resource bases. The Sedekon ART project is implemented in three sites. Annex B and Annex C provide the distribution of ART patients by district and the ART extension plan by 2005, respectively.

***Availability of VCT, PMTCT, and ARV Services in Borgou/Alibori and Zou/Collines.*** Currently, a total of six and four maternity centers provide PMTCT services in the Borgou/Alibori and Zou/Collines, respectively. All selected sites for the extension phase have secured support from the Global Fund, the Glaxo Foundation, or the United Nations Children's Fund (UNICEF). The list of sites selected for the extension phase is provided in Annex A, along with specified health zones and related sites supported by the respective development partners.

VCT services are available at six and 11 health facilities in Borgou/Alibori and Zou/Collines, respectively. These facilities have provided VCT services to a total of 1,150 and 9,910 people in Borgou/Alibori and Zou/Collines, respectively. As of May 2005, three ART sites existed in Borgou/Alibori and Zou/Collines. These sites manage a total of 112 and 200 clients in Borgou/Alibori and Zou/Collines, respectively. The CRS-supported Sedekon project alone provided ARV drugs to 77 PLWHA in 2004–2005 and provided care and support to a total of 251 PLWHA between 2001 and 2005.

### **COMMUNITY OPENNESS TO VCT AND PMTCT**

According to the 2001 Benin Demographic and Health Survey, 62.1% and 63.5% of the male and female populations (ages 15–64 years), respectively, reported a desire to be tested—68% among men and 62.5% among women in Borgou, and 59.7% among men and 68.7% among women in Zou. The younger population of males (ages 15–29 years) reported a stronger desire for HIV testing (64.1–67.9%) than did the older population (52.3–61%). However, overall only 6.8% of males and 5.1% of females reported having

been tested, compared with 15.4–17.1%, male and female respectively, for the most educated segment of the population (secondary education and over). The incredible achievements of PPLS in promoting the use of VCT services speak positively to the growing openness to voluntary HIV testing in Benin.

The four-year, pilot PMTCT experience indicates a high level (>90%) of acceptance for HIV testing. The MOH/PNLS is currently conducting a range of nine socio-anthropological studies that focus on pregnant women, men, service providers, and community leaders in different districts to communicate the expansion of PMTCT interventions. Thus far, three studies have been completed with support from UNICEF and the Global Fund. UNICEF with PPLS funding will implement four of them. These targeted socio-anthropological studies and selected interviews of stakeholders and clients conducted during this consultancy confirm the readiness of pregnant women to undergo HIV testing.

### **THE CODIFIED AND LEGAL ENVIRONMENT FOR ADDRESSING HIV/AIDS IN BENIN**

Following the adoption of two important laws relevant to HIV/AIDS prevention and care, Law 2003–04, passed in March 2003, and Law 2000, passed in August 2004, relating to Sexual and Reproductive Health and the Family Code, the MOH with the support of the USAID-funded project BHAPP is currently reviewing with various stakeholders a specific law for fighting HIV/AIDS. That law will empower relevant authorities and players to further protect people living with HIV/AIDS as well as the seronegative population. A key feature of the proposed law is to protect the privacy and confidentiality of people living with HIV/AIDS and to empower service providers to share testing results, under specific conditions, with the sexual partners who are likely to be infected.

### **INTEGRATION OF HIV TESTING AND COUNSELING INTO THE EXISTING SERVICE DELIVERY SYSTEM**

Although not directly focused on HIV/AIDS (particularly VCT and PMTCT), the Benin Integrated Family Health Program [*Promotion Intégrée de Santé Familiale* (PROSAF)] has accomplished excellent results in developing and expanding a simple model of integration of services in its intervention zones. That model has facilitated the integration and scale-up of PMTCT services. Important lessons have been learned during the process of introducing this integrated package of services. Those lessons can be built upon for the planned expansion of PMTCT and ARV services. Key lessons learned include:

- Get management and service providers and support staff on board and have them sign off on the integration plan
- Support the development of local leadership
- Define integration in the context and resource base of the health center
- Assess both space and equipment requirements for an improved and supportive working environment
- Study and optimize patient flow, organization, and delivery of services
- Develop and implement training, coaching, and a facilitative supervision plan

- Establish a quality improvement system aligned with the core objectives of the interventions
- Facilitate mutual learning and sharing of experiences among service providers of different facilities
- Reward and appreciate all efforts of service providers

### **COLLABORATION AMONG KEY STAKEHOLDERS AND IMPLEMENTING PARTNERS**

Several good examples exist of collaboration that has contributed to expanding the cluster of good-quality HIV/AIDS services to the populations. BHAPP has developed a close collaboration with the MOH/PNLS for the development of HIV-testing-related norms and standards documents, thus facilitating the adoption of competency-based training and supervision methodology for trainers in ART service provision and advocacy for the law related to HIV prevention and the fight against HIV/AIDS. As importantly, BHAPP is leveraging its excellent relations with the MOH/PNLS to direct the Global Fund to cofinance the priority capacity-building activities of MOH/PNLS. PSI also has a long tradition of mobilizing resources from development partners other than USAID.

### **IMPLEMENTATION GAPS**

We identified three critical implementation gaps: 1) addressing stigma and partner notification; 2) monitoring compliance against norms and standards; and 3) building a decentralized and supportive infrastructure for HIV/AIDS prevention, care, and support

#### **ADDRESSING STIGMA AND DISCLOSURE OF RESULTS/PARTNER NOTIFICATION**

This is the most critical single implementation challenge. One interesting result of the ongoing socio-anthropological studies is the reported willingness of pregnant women to share an HIV-positive result with their husbands (92.5% of women in the health zone of Pobe-Ketou-Adja-Ouere). Yet, interviews of all key players engaged in promoting VCT, PMTCT, and ARV services indicated that the most serious single programmatic challenge facing these interventions is the lack of partner notification of positive test results. The return of the investment in promoting VCT and PMTCT may be very disappointing if people who test HIV-positive do not inform and protect their partners. HIV testing is currently seen as an end in itself and not perceived as a means to prevent further infections and to foster care and support to people living with HIV/AIDS. The interventions employed in the SIDA project that targeted sex workers have prevented 50% of new HIV cases among sex workers and only one-third of new infections in the general population. Thus, it is essential to place continued and greater effort on “prevention among positives” in the general population. This is of utmost importance when considering that an important proportion of HIV-seropositive couples may be discordant. The 2004 HIV sero-survey in Uganda indicates that about 50% of HIV seropositive couples are discordant.

The failure in partner notification is largely associated with the overwhelmingly stigmatized climate of living with HIV/AIDS in Benin. There are countless anecdotal reports of people who committed suicide and women who were chased out of their homes by husbands and/or in-laws. PMTCT service providers have also mentioned the lack of HIV test kits for male partners as an issue.

This failure in disclosure of HIV test results is not surprising. The three core issues that need urgent attention are: 1) the non-involvement of local community leaders in addressing this stigma; 2) the persistent, outdated, and inadequate communication strategy and related negative perception of HIV/AIDS as a killer; and 3) the emotional and societal burden placed on individuals to share their test results without any institutional and societal support. With respect to improving communication on HIV/AIDS, PSI is implementing a multifaceted, positive mass media campaign that links HIV to love and encourages young people to know their HIV serostatus.

The growing recognition of this critical failure in disclosure of HIV test results is opening the way to emerging initiatives for correcting this unfortunate situation. The initiatives include strengthening support provided to people living with HIV/AIDS and their growing involvement in support of program implementation through testimonials. PLWHA also act as intermediaries between health facilities and communities. They facilitate communication among service providers and clients and also support community outreaches organized by health centers.

A related implementation gap is the relatively low proportion, less than 60%,<sup>3</sup> of HIV-tested clients who return to obtain their test results. The current policy is to not provide the test results the same day that pretest counseling is conducted. This policy is believed to stimulate deep reflection about past behaviors and the need for behavior change as the client awaits the results. The same-day-testing/same-day-result policy has proven to increase performance of HIV testing and counseling by: 1) allowing most clients to receive their results and benefit from post-test counseling, which provides opportunities to promote behavior change among both seropositive and seronegative clients; and 2) directing eligible clients to health centers that provide care and support. In many countries, the same-day-testing/same-day-result policy is now considered to be one of the best HIV-related practices.

#### **MONITORING COMPLIANCE AGAINST NORMS, STANDARDS AND EFFECTIVE PRACTICES**

With the exception of HIV testing policy guidelines, norms, and standards for PMTCT and the related training modules completed in 2003, HIV testing policy documents have been only recently completed and validated in 2005. These norms and standards documents have not been disseminated. Most importantly, the lessons learned and effective practices are only known by a limited number of key program managers and service providers.

Despite this situation, ongoing training of service providers for the launch and expansion of PMTCT, VCT, and ARV services has provided several opportunities to raise knowledge, awareness, and practices for compliance with the overall basic principles and related practices of the HIV testing policy. Currently, it is fair to state that trained service providers who are operating PMTCT, VCT, and ARV services:

- Are aware of confidentiality and consent requirements
- Provide pre- and posttest counseling
- Follow the established testing algorithm

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<sup>3</sup> This percentage was consistently mentioned by people who were interviewed, but no supporting documentation was available.

- Comply with quality control of HIV test results when the quality control system is established, as is the case for PMTCT
- Refer HIV-positive clients to designated structures for care and support

As the norms and standards are disseminated more widely, it will be essential to establish a system for assessing and continuously improving compliance performance and use of effective practices.

#### **BUILDING A DECENTRALIZED AND SUPPORTIVE INFRASTRUCTURE FOR HIV/AIDS PREVENTION, CARE, AND SUPPORT**

Based on the HIV/AIDS funding allocated by the Government of Benin and the Global Fund, the MOH/PNLS has taken advantage of substantially increased funding for HIV/AIDS to build a network of five CIPECs in the headquarters of five districts to spearhead the decentralization of the fight against HIV/AIDS in each district. Each CIPEC also includes a laboratory facility to serve as a reference for HIV/AIDS-related biological testing.

The CIPECs are not yet fully operational. Current utilization of the CIPECs is low based on several factors, including accessibility by remote populations. VCT outreach conducted by health centers in collaboration with the CIPECs has proven difficult because of the limited number of trained personnel. The CIPECs also need considerable support in order to institutionalize quality assurance procedures. The national reference laboratory is facing similar problems.

### **RECOMMENDATIONS**

**Recommendation 1.** As articulated in the USAID/Benin HIV/AIDS Strategy, the Mission should build on the current momentum achieved in HIV testing and counseling and contribute to scale-up of PMTCT, VCT, and ARV services by making collaboration the centerpiece of its program assistance strategy. USAID should position its technical assistance, both at the national level and district level, to develop partnerships and leverage resources in order to avoid piecemeal interventions. Accordingly, in view of its currently limited HIV/AIDS resources of \$2 million per year, USAID/Benin should pursue a systematic collaborative strategy that supports and builds on investments made by larger funding agencies, such as the World Bank and Global Fund. This new proposed approach to mainstreaming the USAID comparative advantages may require a change in the USAID culture for development assistance. USAID/Benin may have to systematically provide a complementary cluster of services with respect to its comparative advantages in capacity building, quality assurance, training, and strengthening supervision and performance improvement systems. In so doing, USAID may adopt a truly collaborative approach that will extend the reach and quality of interventions developed by the implementing partners who rely on funding institutions with larger financial resources for service delivery, e.g., PPLS, the Global Fund, and MOH. In conclusion, this means that USAID/Benin should reconcile its agenda with those of its partners, which may require a change in the manner in which USAID operates and programs its resources.

**Recommendation 2.** USAID/Benin should lead the realignment of testing and counseling interventions by using its core objectives of contributing to attitude and behavior change. Performance of implementing partners should not only be measured by the number of people tested, but also with the following illustrative performance indicators:

- the proportion of people who received their test results
- the proportion of people tested who shared their results with their partners
- the proportion of people living with HIV/AIDS who experienced discrimination and accessed support services (including legal services)

**Recommendation 3.** USAID should first and foremost dedicate its resources to monitoring, documenting, and establishing a rapid feedback system that can: assess and address the implementation gaps affecting compliance with existing norms, standards, and protocols; and determine the achievement of public health objectives, as well as refine and disseminate lessons already learned and current effective interventions. No need exists to place any USAID resources toward developing norms and standards in HIV testing policy and practices. These standards already exist and provide the basic framework for the scale-up of VCT, PMTCT, and ARVs. As discussed above, a major threat to Benin's opportunities to make qualitative progress toward addressing the HIV/AIDS epidemic would be to allow the implementing partners of the new USAID assistance program to disregard achievements to date and/or to "fix" supporting tools or design new systems without gaining substantial and documented insights from the wealth of current activities.

The potential of AMCES, the network of the association of faith-based organizations for health, remains largely underutilized. USAID/Benin should highlight such potential and direct MOH and development partners to fully take advantage of this effective network of dedicated service providers.

**Recommendation 4.** With the planned widening of services, a need and a demand have been created for strengthening quality assurance systems for HIV testing, counseling services, training and supervision, logistics and management of tests kits, supplies and drugs, resource planning and allocations, and institutional and organizational behavior.

**Recommendation 5.** With the increased availability of rapid HIV tests, Benin should consider testing the best practice of same-day-testing/same-day-result and providing HIV testing in clinical settings for TB patients. Adopting this best practice of same-day-testing/same-day-result would increase the number of post-test counseling significantly. Further, with other development partners, USAID/Benin should introduce routine HIV testing for TB patients in health centers.

**Recommendation 6.** An urgent need has arisen to support targeted prevention activities among positive clients. An important tool for positive clients to use to address discrimination will be laws related to HIV prevention and the fight against HIV/AIDS. However, it will be essential to disseminate such information and expand support mechanisms to facilitate access to legal services by PLWHA associations and other vulnerable populations. A vigorous, culturally sensitive support strategy for reducing social stigma and discrimination should accompany such prevention interventions among the positive clients.

## **ANNEXES**



## ANNEX A: PMTCT EXTENSION PLAN BY DEVELOPMENT PARTNER

Health Districts	Sub-Districts (Communes)	Maternity Health Centers	Partners
Alibori	Karimama	CSSP Karimama	Global Fund
	Malanville	CCS Guene	
		CCS Madekali	
		CCS Urbain	
		HZ Malanville	
	Banikoara	CCS Founougo	
		CCS Gomparou	
		CCS Goumon	
		CCS Toura	
		HZ Banikoara	
	Gogounou	CCS Bagou	
		CSSP Gogounou	
	Kandi	CCS Angaradebou	
		CCS Sonsoro	
		HZ Kandi	
	Segbana	CCS Libante	
		CSSP Segbana	
Atacora	Kobly	CCS Kobli	World Bank
	Materi	CCS Dassari	
		CCS Gouande	
		CCS Materi	
		CCS Tantega	
	Tanguieta	CCS N'dahonta	
		HZ Tanguieta	
	Boukoumbe	CCS Boukoumbe	
	Natitingou	CSCU Natitingou	
		HZ Natitingou	
	Kerou	Cspr Brignamaro	
		CSSP Kerou	

Health Districts	Sub-Districts (Communes)	Maternity Health Centers	Partners
Atacora (continued)	Kouande	CCS Guilmaro	
		HZ Kouande	
	Pehunco	CSSP Pehunco	
Atlantique	Abomey-Calavi	HZ Abomey-Calavi	French Cooperation and UNICEF
		Akassato	
		Godomey	
		Hevie	
		Ouedo	
		Kpankoun	
		Ste Marie De Calavi	
		Glodjigbé	
		St Antoine De Padou	
		Zinvie	
	Allada	HZ Allada	Global Fund
		Sekou	
	Toffo	Houegbo	
		Sehoue	
	Ze	Dodji-Bata	
	So-Ava	So-Ava	
	Kpomasse	Tokpa-Domey	
	Ouidah	Ouidah (HZ)	
Borgou	Parakou	CHD Borgou	Glaxo Foundation
		CSCU Parakou (HZ)	
		CCS Kpebie	
		CCS Madina	
		CCS Zongo	
	N'dali	CSSP N'dali	Global Fund
	Kalale	CCS Bouka	
		CCS Derassi	
		CCS Dunkassa	
	Nikki	HZ Nikki	

Health Districts	Sub-Districts (Communes)	Maternity Health Centers	Partners
Borgou (continued)	Perere	CSSP Perere	
	Tchaourou	CCS Beterou	
		CCS Tchatchou	
		CSSP Tchaourou (HZ)	
		Hop Papane	
Collines	Dassa-Zoume	CCS Paouignan	World Bank
		CCS Soclogbo	
		CSSP Dassa	
		Hopital Dassa (HZ)	
	Glazoue	CCS Aklampa	
		CCS Thio	
		CSSP Glazoue	
	Ouesse	CSSP Ouesse	
	Save	CSSP Save	
	Bante	CCS Gouka	
		CSSP Bante	
	Savalou	CCS Doume	
		CCS Tchetti	
		CCS Savalou	
		HZ Savalou	
Couffo	Aplahoue	CCS Atomey	Plan Benin
		CCS Houetan	
		CCS Lonkly	
		Cli Coop Kissame	
		CSSP Aplahoue	
		HZ Aplahoue	
	Djakotomey	CSSP Djakotomey	
		CCS Adjintimey	
	Dogbo-Tota	CSSP Dogbo-Tota	

Health Districts	Sub-Districts (Communes)	Maternity Health Centers	Partners
Couffo (continued)	Klouekanme	CCS Adjahonme	
		CCS Djotto	
		CSSP Klouekanme (HZ)	
	Lalo	CSSP Lalo	
	Toviklin	CCS Adjido	
		CSSP Toviklin	
	Dogbo-Tota	CSSP Dogbo-Tota	Médecins Sans Frontières
	Djakotomey	CCS Gohomey	NGO APH
Donga	Bassila	CCS Manigri	World Bank
		CSSP Bassila (HZ)	
	Djougou	CCS Gaounga	
		CCS Kolokonde	
		CCS Onklou	
		CCS Partago	
		CSCU Djougou (HZ)	
Littoral	Cotonou i	Maternite Lagune	French Cooperation and UNICEF
	Cotonou iv	Ahouansori	
		Cotonou 4 (Aïdjèdo)	
	Cotonou ii	Clinique Alodo1	
		Maternite Cotonou ii	
	Cotonou iii	Cotonou 3	
		St Marie Les Anges	
	Cotonou v	Cotonou 5	
		St Luc	
		Menontin	
		Zogbo	
		Bethesda	

Health Districts	Sub-Districts (Communes)	Maternity Health Centers	Partners
Littoral (continued)	Cotonou vi	Ordh	
		Clinique Oash	
		Jordan	
		Cotonou 6	
		Houenoussou	
		Cms vodje	
		St Pothin	
		Sike	
		St Jean	
		Camp Guezo	
		St Michel	
		Cugo	
Mono	Bopa	CCS Lobogo	Global Fund
	Come	CCS Oumako	
		CSSP Come (HZ)	
	Houeyogbe	CCS Adromey	
		CCS Se	
		CSSP Houeyogbe	
	Athieme	CCS Adohoun	Global Fund
		CSSP Athieme	
	Lokossa	CHD Lokossa	
		Hopital Al Fateh	
		Polycl. Samaritain	
		Porto-Novoi	
	Porto-Novo ii	CCS Hounsouko	
		CCS Zebou	
		Porto-Novo ii	
	Porto-Novo iii	Porto-Novo iii	
	Seme-Kpodji	CCS Aglangandan	
		CCS Ekpe	
		CCS Tohoue	
		Seme-Kpodji	

Health Districts	Sub-Districts (Communes)	Maternity Health Centers	Partners
Mono (continued)	Adjohoun	CCS Azowlisse	
	Bonou	Bonou	
		CCS Dame-Wogon	
	Dangbo	CCS Gbeko	
		Dangbo	
		Disp. Aar	
	Adjarra	Adjara	
		CCS Honvie	
	Akpro-Misserete	Akpro-Misserete	
		CCS Katagon	
		CCS Vakon (7 months)	
	Avrankou	HZ Avrankou	
		CCS Atchoukpa	
		CCS Djomon	
		CCS Gbozounme	
	Adja-Ouere	Adja-Ouere	UNICEF
		CCS Ikpinle	
		Okoakaare	
	Pobe	Pobe	
	Ketou	CCS Adakplame	
		CCS Kpankou	
		Okpometa	
		Ketou	
		Idigny	
	Ifangni	CCS Banigbe	Global Fund
		Doke	
		Ifangni	
	Sakete	CCS Aguidi	
		CCS Ita-Djebou	
		HZ Sakete	

Health Districts	Sub-Districts (Communes)	Maternity Health Centers	Partners
Zou	Abomey	Cab Ste Uriel	World Bank
		CHD-Zou	
	Agbangnizoun	CCS Kinta	
	Djidja	CCS Agouna	
	Bohicon	Cab Deo Gratias	
		CSSP Bohicon (HZ)	
	Za-Kpota	CCS Kpozoun	
		Comp. Sanit Gbelidji	
	Zogbodomey	CCS Cana	
		CCS Zogbodome	
	Cove	CSSP Cove (HZ)	
	Ouinhi	CCS Sagon	
		CSSP Ouinhi	
		Disp Tdh Sagon	
		CSSP Abomey	UNICEF
		CSSP Agbangnizoun	
		CSSP Djidja	



**ANNEX B: PATIENTS UNDER ART AS OF MAY 2005**

DISTRICT	NUMBER OF PATIENTS
Atlantique/Littoral	1,600
Atacora/Donga	136
Borgou/Alibori	112
Mono/Couffo	358
Ouémé/Plateau	376
Zou/Collines	200
<b>TOTAL</b>	<b>2,782</b>



## ANNEX C: EXTENSION PLAN FOR ARV SITES AS OF 2005

N°	Districts	Operational Sites	New ARV Sites to be established	TOTAL
1	Atlantique/Littoral	CNHU Camp Guézo HZ Sourou Léré (Ex CTA) Arc en ciel Clinique des Amis de Cotonou (CM)	HZ Ouidah	6
2	Atacora/Donga	CHD Natitingou HZ Natitingou HZ Tanguéta Ordre de Malte à Djougou	HZ Kouandé HZ Basila	6
3	Borgou/Alibori	CHD Parakou HZ Boko Hopital Evaangélique de Bembèrèkè	HZ Kandi HZ Malanville HZ Nikki HZ Banikouara	7
4	Mono/Couffo	CHD Lokossa HZ Aplahoué MSF Dogbo APH Gohomey	HZ Comé CSCU Grand-Popo	6
5	Ouémé/Plateau	CHD Porto-Novo Centre de Santé Dangbo Clinique Louis Pasteur	HZ Pobè HZ Sakété CSCU Sèmè	6
6	Zou/Collines	CHD Abomey Hopital St Camille Davougon HZ Savalou	HZ Savè HZ Covè	5
	<b>Total</b>	<b>22</b>	<b>14</b>	<b>36</b>



## **ANNEX D: CONTACTS AND PERSONS INTERVIEWED**

### **United States Agency for International Development**

Rudolph Thomas, USAID Mission Director

Pascal Zinzindohoue, Family Health Team Leader

Donald Dickerson, Senior Technical Advisor on HIV/AIDS

Charles Ogouchi, Results and Resources Specialist

Francine Nikoue, Development Assistant Specialist

Blaise Antonio, Program Assistant

### **National Program against HIV/AIDS**

Dr. Edgard Lafia, Deputy Coordinator

Mathurin Lougbegnon, Physician in Charge of Care, Treatment and Support (*Médecin, Service Prise en Charge*)

Dr. Isidore Adeyanju, Physician, PETRAME/PMTCT

### **Multisectoral Project for the Fight against HIV/AIDS (*Projet Pluri-sectoriel de Lutte contre le VIH/SIDA (PPLS)*)**

Dr. Olivier Bienvenu Capo-Chichi, M.D., National Coordinator

Dahoun Maxime, Ph.D., in charge of Monitoring and Evaluation

### **Information and Counseling Centers [*Centre d'Informations, de Prospectives Et de Conseils (CIPEC)*]**

Gilbert H. Degbelo, Biomedical Engineer, Zou/Collines

Dr. Fatima Afouda, PMTCT Coordinator, Zou/Collines

Dr. Bello Saka, Borgou/Alibori

Dr. Nicole Gnanhoui-Paqui, Zou/Colline

Dr. Alice Sènam Gougounon, PMTCT Coordinator, Borgou Alibori

### **Center for Blood Transfusion, Zou/Collines**

Atinkpinda Martin, Biomedical Engineer

**Sub-district Health Center, CSC-Parakou**

Delphine Nekoua, Nurse in Charge

**Parish Health Center, CSA-Parakou**

Boulaku Aphilomene

Aihonnou E. Jeronime

Agoli-Agbo Pulchery

15 pregnant women participants in a group interview

**OSV/Jordan-NGO**

Josephat Avoce, Director

Rafiou Baguidi, Regional Coordinator

Todegni Angelo, Laboratory Technician

Issifou Allasane; Information, Education, and Communication Specialist

Houngbo C. Simon, Counselor

Faton Christian, Social Worker

Adjanou Isabelle, Receptionist/Counselor

Soule Issifaou, Social Worker

Cocou Nomique, Physician

Audace Attakpenou, Social Worker

Justin Zoundjan, Pharmacist Assistant

Sossou Emma, Counselor

**Racines NGO**

Dr. Alice Godonou, ART Coordinator

Alice Senami Goucounon, in charge of Care, Treatment and Support

**Health Center-St Camille de Davougou**

Père Bernard Moegle, in Charge

**Médecins Sans Frontières**

Bruno Guillaume Kerzmann, Chief of Party, HIV/AIDS Project

**Canadian Cooperation West African HIV/AIDS Program (Projet SIDA 3 Bénin)**

Agbla Felix M.D. M.P.H., Adjunct National Coordinator

**Population Service National**

Ghislain G.E. Kouton, Coordinator for Armed Forces Project

Serge D. Attolou, in charge of Communication Support

**Partners for Health Reform*plus* Project (PHR*plus*)**

Mr. Mbengue, Chief of Party

**Benin Integrated Family Health Program, PROSAF, University Research Corporation**

Aguima Frank Tankoano, M.D., M.P.H., Transition Phase Chief of Party

Karki Mahamane, Ph.D., Transition Phase Quality Assurance Advisor

**Health Zone-Tchaourou**

Dr. Mongbo M. Yves Armand, Public Health Physician, Coordinator

**District Health Hospital-Boko**

Serge Sare-Sedekon, Coordinator

Emmanuel Ufia, Administrator

Dr. Koussene Achille, Physician

**United Nations Development Programme/Global Fund to Fight AIDS, Tuberculosis and Malaria**

Alain Akpadji, Coordinator

**National Medical Store (*Centrale D'achat des médicaments essentiels et consommables Médicaux*)**

Dr. Coffi Pascal Hessou, Pharmacist

Pharmacist, Director

**Benin HIV/AIDS Prevention Project**

Mbella Ngongi, Chief of Party

Dr. Karim Seck, in charge of Surveillance

Dr. Edmond B. Kifouly, M.P.H., M.Sc., in charge of Communication

Gilbert Balogoun, Regional Coordinator, Zou/Collines

Edmond Bernard Gbemetonou, Regional Coordinator, Mono/Couff

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